# PROCEDURES FOR RESTRICTION PROGRAM
# ELIGIBILITY, ENROLLMENT, DATA ENTRY, & TERMINATION

## NUMBER OF REVIEWS REQUIRED

In the Restriction Program, Health Care Financing Administration (HCFA) requires that for each quarter the State must review at least 0.01 percent of the total body of active Medicaid recipients not enrolled in an HMO. An active Medicaid recipient is defined as someone who incurred at least one paid service during the year.

The Restriction Program Manager obtains the above figure from the manager of the Finance Unit.

## ELIGIBILITY

Financial/medical eligibility for the Restriction Program is determined by the Office of Work Force Services (DWS), the Bureau of Eligibility Services offices (BES). Any person who has received a Medicaid card over the past 12 months is eligible for review (if they have had at least one paid service during the year).

*Exceptions* to this are made when a complaint is received on someone who has had Medicaid eligibility for less than one year. In those cases, investigations of abuse allegations are appropriately completed and are reviewed.

The federal review selection of clients is made from the Exception Log generated by S/URS each quarter. Those with the highest number of exception points are reviewed. All cases referred as complaints are reviewed. Only currently eligible clients are reviewed.

Clients enrolled with a Health Maintenance Organization (HMO), are excluded from the federal SURS review. For HMO cases being reviewed from complaints, the HMO will be asked to provide claims history.

Once the investigation is completed (with input from consultant physicians when needed), the client is enrolled in the Restriction Program, with a primary physician and pharmacy listed on his/her medical card. Children of over utilizing clients will ordinarily not be enrolled in the Restriction Program unless their Claim History Detail Report (CHDR) indicates the parent may be over utilizing services for them.

Should any question arise concerning whether or not utilization is excessive as detailed in the CHDR, the Restriction Program Manager seeks advice from Medicaid physician consultants. This is implied in CFR 456.6.

**CRITERIA FOR EVALUATING OVER UTILIZATION OR ABUSE OF MEDICAID SERVICES BY MEDICAID ELIGIBLE CLIENTS**

These guidelines form the basis for recommending a client be evaluated for enrollment in the Restriction Program. One or more of the following criteria or a combination of several criteria may constitute over utilization and/or abuse of medical services from a medical, business or fiscal standpoint.

1. Physician Over Utilization

Use of more than 4 to 6 medical or surgical specialists, not including specialties such as anesthesiology, radiology, pathology, or assistant surgeons, providing services to a client within a 12-month period.

More than 4 different physicians providing same or similar medical services within a 12-month period.

Clear indications of duplication of services for the same diagnosis unless it is a second opinion for intended and necessary surgery.

The major diagnoses of the client as listed in the CHDR's are always considered. Ordinarily, only physicians that provide ambulatory care are counted.

2. Abuse Potential Drug Over Utilization

Unless the patient has an intractable and/or terminal illness associated with acute pain (such as cancer), the following guidelines are used:

a. Clients with an average daily intake of 3 to 4 drug doses of Schedule II, III, and/or IV drugs coming from more than one prescriber over a six-month period, should be enrolled in the Restriction Program. Schedule III and IV drugs are habituating rather than addicting drugs, but can be over utilized.
b. Prescriptions for Schedule II, III, &/or IV drugs being prescribed concurrently by 2 or more prescribers.

3. Pharmacy Over Utilization

Any client who is concurrently utilizing services from more than 3 different pharmacies, when there is evidence of potential or possible drug dependency of abuse potential substances or where there is an allegation by a pharmacist or other professional of abuse potential drug over utilization.

4. Forged, Altered, or Bogus Prescriptions

Any referral from a reliable source where there is documented evidence that forgery has occurred will be grounds for immediate Restriction.

5. Emergency Room Abuse

Clients who have 3 or more emergency room visits in any one year for non-life threatening medical conditions and/or "routine" care that could be treated in the primary physician's office.

Emergency room claims with a diagnosis of drug abuse or dependance will be evaluated for Restriction.

6. Dental Over Utilization

More than 2 general practice dentists within a 12 month period unless evidence of a move to an area that would make accessibility impossible. Visits to several dentists for exam and x-rays but no follow up services, are signs of possible over utilization.

7. Podiatry Over Utilization

More than 2 podiatrists in a 12 month period showing clear indications of duplication of services for the same diagnosis unless it is a second opinion for intended &/or necessary surgery.

8. Review of Diagnoses

Cases where clients have a diagnosis of drug dependency, alcohol abuse or a miscellany of unrelated diagnoses, or diagnoses that would indicate the potential or possibility of drug or alcohol abuse will be reviewed.

**PROCEDURES FOR CLIENT ENROLLMENT IN THE RESTRICTION PROGRAM**

The Restriction Program Staff will review CHDRs &/or HMO histories of clients identified on the SURS Exception Log and by referral to determine if Restriction would be appropriate. If any questions exist about the seriousness of the client's medical problems &/or consequent need for care from numerous physicians, a conference is held with physician consultants.

If use does not justify Restriction at this point, an Education letter explaining:

- The importance of a primary physician,
- The proper use of the emergency room,
- Following their doctor's prescribed treatment plan, and
- The importance of using 1 pharmacy for all prescriptions,

will be sent to the client and the case will be pended for 6 month follow up review.

If use justifies Restriction, the following steps are taken:

1. Send packet number one to client:

   a. A Certified letter giving federal guidelines of authority to Restrict, describing over-utilization, listing name of a primary care physician and a pharmacy, and giving hearing rights;
   b. Self-addressed return envelope;
   c. A "Request for Agency Conference or Hearing" form.

2. Send packet number two regular mail within two days containing same information as above.

3. If the client responds, either an in-office interview or a telephone conference is held with the client. Discussion of over utilization is completed at this time. A decision regarding Restriction &/or a change of providers should be made at this time.

4. If the client wants to appeal enrollment in the Restriction, they are advised to complete and return the "Request for Agency Conference or Hearing" form within 10 days of the date on the Restriction letter.

5. A case file is set up on Data Ease with client information and a narrative of any conversation with the client or primary care providers is logged.

6. If a clients returns the "Request for Agency Conference or Hearing" form appealing Restriction, the form is given to the hearing officer's clerk and a pre-hearing telephone conference is scheduled. For clients enrolled with an HMO, the HMO is asked to send a representative to attend the pre-hearing conference with any pertinent information regarding medical over utilization.

**PROCEDURES FOR CHANGING PHYSICIAN AND/OR PHARMACY**

1. If a client requests a change of their Primary Care Physician (PCP) after medical cards have been printed, the client will have to stay with provider listed on the medical card for the remainder of the month or have a referral from the primary care provider listed on their medical card. Before the change is made, the new physician will be contacted to see if he/she will serve as PCP.

2. HMO premiums are prepaid at time of benefit issuance. Clients wanting a change of HMO after benefit issuance, must finish out the entire month with the HMO or pay themselves for outside services. Any exception to this must go through top management.

3. If client has moved and selected a pharmacy in the new location, they will have to use original primary pharmacy for the remainder of the month if at all possible, or use new pharmacy during regular business hours so Restriction Program staff can force claims on the "on line" billing system.

4. Provider changes are approved and documented by Restriction Program staff and the HMO representative, where appropriate.

5. Primary care providers may request termination of a client from their practice by sending a written notice to the client, giving them 30 days to locate a new primary care provider, and sending a copy to the Medicaid Recipient Restriction Program staff and HMO if applicable.

6. Clients who have been discharged from 3 or more Primary Care Practices, will automatically be assigned to the nearest Health Clinics of Utah facility as Primary Care.

**REVIEW OF CLIENTS IN RESTRICTION PROGRAM AFTER ONE YEAR**

After one year of enrollment in the Restriction Program, a review of the clients use will only be done when requested by the client. Otherwise, client will remain on Restriction. If upon review it is found that the client is still visiting emergency rooms or urgent care facilities, additional pharmacies and/or physicians beyond his/her primary physician (without a referral), the client will remain on restriction. In some cases of extreme over utilization, the hospital emergency rooms, the PCP, and the HMO, where appropriate, may be contacted and the case discussed on how to educate the client on proper medical care.

When prescribing over utilization is of concern, the primary care pharmacy will be contacted and reminded that prescriptions for controlled or abuse potential drugs from a provider other than the PCP, must be cleared with the PCP before dispensing.

At the clients request, the Restriction Program Staff reviews with the client his/her CHDR, pointing out over utilization concerns. This can be done by telephone or by a face to face interview. The client is asked to explain reasons for continued over utilization. If the reasons are justified, the Restriction Program Staff will contact the clients PCP and discuss the reasons. Restriction can be removed with the PCP's recommendation.

**TERMINATION OF CLIENT FROM RESTRICTION PROGRAM**

For clients <u>being terminated</u> from the Restriction Program the following procedures will be followed:

1. Mail a termination letter to the client, advising the primary care provider on their Restriction card will be left as a case management provider or those enrolled with an HMO, will be left with the HMO listed on their card.

2. Place copy in clients permanent file,

3. Send copy of the PF 5 screen to the HMO representative, where appropriate and do an alert on the EWAL PACMIS screen for the Case Worker.

**MONITORING OF RESTRICTION PROGRAM COST SAVINGS**

Cost savings in the Restriction Program are determined quarterly in the following manner:

1. On an individual client basis, a cost comparison is made between the total cost to Medicaid of:

   a. The cost of client's utilization of services for the year prior to Restriction, and the cost of that client's utilization after enrollment in Restriction, excluding inpatient hospital payments only, checking the eligibility file to verify continuous eligibility.

2. In cases where the costs of Medicaid increase during the year after the client is enrolled in Restriction, the Restriction Program Staff will evaluate the medical claims for evidence of changes in medical need. If questions arise as to whether increased use is justified, the physician consultant will be contacted &/or medical records will be requested from the PCP &/or hospitals.

3. In cases where the client continues to intentionally over utilize Medicaid services, the Restriction Program Manager will request the PCP or HMO representative, where appropriate, to negotiate a Behavioral Contract with the client aimed at improving his/her utilization. Again, the client is informed that over the coming year, his/her utilization will be closely monitored for any deviations from the Contract.